[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]

WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF

NORTHWESTERN MUTUAL LIFE INSURANCE COMPANY (THE)
NAIC # 67091 CDI # 0153-7

NORTHWESTERN LONG TERM CARE INSURANCE COMPANY
NAIC # 69000 CDI # 2126-1

AS OF JULY 31, 2009

ADOPTED OCTOBER 8, 2010

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

TABLE OF CONTENTS

SALUTATION 1
FOREWORD 2
SCOPE OF THE EXAMINATION 3
EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED 4
RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS 6
DETAILS OF THE CURRENT EXAMINATION 7
TABLE OF TOTAL CITATIONS 9
TABLE OF CITATIONS BY LINE OF BUSINESS 12
SUMMARY OF EXAMINATION RESULTS 14

DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

October 8, 2010

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

Northwestern Mutual Life Insurance Company (The)
NAIC # 67091

Northwestern Long Term Care Insurance Company
NAIC # 69000

Group NAIC # 0860

Hereinafter, the Companies listed above also will be referred to as NMLIC, NLTC or the Company or, collectively, as the Companies.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination covered the claims handling practices of the aforementioned Companies on claims closed during the period from August 1, 2008 through July 31, 2009, and claims open as of July 31, 2009. The examination was made to discover, in general, if these and other operating procedures of the Companies conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Companies' responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about these Companies closed by the CDI during the period August 1, 2008 through July 31, 2009; a review of previous CDI market conduct claims examination reports on these Companies; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the California Department of Insurance in Sacramento, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims reviewed were open as of July 31, 2009, or closed from August 1, 2008 through July 31, 2009, referred to as the "review period". The Individual Disability Income, Group Disability Income and Long Term Care categories included the open claims. The examiners selected randomly for some categories and entirely for other categories, 168 NMLIC claims files and 25 NLTC policies and associated claim files for examination. The total number of NMLIC and NLTC claims files/policies reviewed was 193. The examiners cited 260 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

This examination included findings in Individual Disability Income, Group Disability Income, Individual Life and Long Term Care claims.

INDIVIDUAL AND GROUP DISABILITY INCOME

Findings in the Disability Income line of business included the following: failure to identify the source of an offset on the Statement of Disability Benefits; failure to provide a clear explanation of the computation of benefits; failure of the Company to follow its procedure to provide a status letter to the insured or the claimant every 30 days; failure to disclose all benefits that may apply to a claim; and failure to reference the California Department of Insurance in its claim denials.

INDIVIDUAL LIFE INSURANCE

Findings in the Individual Life line of business identified the Company's failure to notify the beneficiary of the specified rate of interest paid on a death benefit and failure to follow its procedure to provide a status letter to the insured every 30 days.

LONG TERM CARE

Findings in the Long Term Care line of business included the following: failure to reference the California Department of Insurance in its claim denials; failure of the Company to follow its procedure to provide a status letter to the insured every 30 days; and failure to disclose all benefits that may apply to a claim.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

Except as noted below, market analysis did not identify any specific issues of concern.

The Companies were the subject of five California consumer complaints and inquiries closed from August 1, 2008 through July 31, 2009, in regard to the lines of business reviewed in this examination. All five complaints and inquiries involved Individual Disability Income. Of the complaints and inquiries, the CDI determined the complaints were not justified. There were no specific areas of concern identified in the complaint review.

The previous claims examination conducted upon Northwestern Mutual Life Insurance Company (NMLIC) reviewed a period from June 30, 2001 through July 1, 2002. The noncompliance issues identified in the previous examination report were NMLIC's failure to reference the CDI in a Group Disability Income claim denial, failure to pay benefits, including interest, to the insured/claimant within 30 calendar days in an Individual Disability Income file, and failure to specify the rate of interest for Life claims. The examiner focused on these issues during the course of the file review and these issues were identified in the current examination.

There have been no prior claims examinations conducted upon Northwestern Long Term Care Insurance Company (NLTC).

NMLIC and NLTC were not the subjects of any prior California Department of Insurance enforcement actions.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

NMLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**NUMBER OF ALLEGED CITATIONS**
Accident and Disability (A & D) / Individual Disability Income Paid	342	17	37
A & D / Individual Disability Income Denied or Closed Without Payment (CWP)*	108	11	4
A & D / Individual Disability Income Pending**	54	5	18
A & D / Group Long Term Disability Income Paid	58	19	56
A & D / Group Long Term Disability Income Denied or CWP*	10	10	8
A & D / Group Long Term Disability Income Appeals	3	3	6
A & D / Group Long Term Disability Income Pending**	3	2	0
A & D / Group Short Term Disability Income Paid	61	7	46
A & D / Group Short Term Disability Income Denied or CWP*	5	5	10
A & D / Group Short Term Disability Income Appeals	1	1	2
A & D / Group Short Term Disability Income Pending**	6	1	5
Individual Life Insurance / Paid	1,087	60	13
Individual Life Insurance / Denied	2	2	17
Individual Annuities	52	25	0
TOTALS	1,792	168	222

NLTC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**NUMBER OF ALLEGED CITATIONS**
Accident and Disability (A & D) / Long Term Care Paid	7	7	20
A & D / Long Term Care CWP	11	11	7
A & D / Long Term Care Denied	1	1	5
A & D / Long Term Care Pending**	6	6	6
TOTALS	25	25	38

* Denied or CWP Category – The Company did not differentiate between Denied and CWP claims; therefore, this category contains both denied claims and those that were closed without payment for other reasons.

** Pending Category - This category was comprised of claims upon which the Company had yet to make a decision to accept or deny the claim.

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	NMLIC Number of Alleged Citations	NLTC Number of Alleged Citations
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide to the claimant and assignee, if any, an explanation of benefits including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.	123	0
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	36	7
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to reference the California Department of Insurance in its claim denial.	9	18
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	12	6
CIC §10172.5(c) *[CIC §790.03(h)(3)]	The Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit.	12	0
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	3	1
CIC §1879.2(a) [General Citation] *[CIC §790.03(h)(3)]	The Company failed to include the California fraud warning on insurance forms.	3	1
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim, or it persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. [The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.]	6	2
CIC §10111.2(b) *[CIC §790.03(h)(3)]	The Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim.	3	0
CIC §10111.2(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability.	3	0

Citation	Description of Allegation	NMLIC Number of Alleged Citations	NLTC Number of Alleged Citations
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	3	0
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions.	2	1
CIC §10111.2(a) *[CIC §790.03(h)(5)]	The Company failed to pay benefits within 30 calendar days from receipt of information needed to determine liability.	2	0
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	0	1
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.	1	0
CIC §10172.5(a) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a death claim, under a disability policy, that was paid longer than 30 days from the date of death of the insured, pursuant to CIC §10174.	1	0
CIC §10235.9(b) *[CIC §790.03(h)(13)]	The Company failed to provide the insured whose claim was denied a written notice within 40 days of the date of denial with the reasons for the denial and all information directly related to the denial.	0	1
CCR §2695.5(e)(1) *[CIC §790.03(h)(2)]	The Company failed to acknowledge notice of claim within 15 calendar days.	1	0
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	The Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	1	0
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1	0
Total Number of Citations		**222**	**38**

*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
CIC §790.03(h)(2)	The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
CIC §790.03(h)(4)	The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
CIC §790.03(h)(13)	The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

TABLE OF CITATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY **Disability Income** **2008 Written Premium: $72,300,271** **AMOUNT OF RECOVERIES $21,773.30**	**NUMBER OF CITATIONS**
CCR §2695.11(b) [CIC §790.03(h)(3)]	123
CIC §790.03(h)(3)	26
CCR §2695.4(a) [CIC §790.03(h)(1)]	12
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	6
CCR §2695.7(d) [CIC §790.03(h)(3)]	5
CIC §790.03(h)(5)	3
CIC §10111.2(b) [CIC §790.03(h)(3)]	3
CIC §10111.2(c) [CIC §790.03(h)(5)]	3
CCR §2695.5(b) [CIC §790.03(h)(2)]	3
CIC §1879.2(a) [CIC §790.03(h)(3)]	2
CIC §10111.2(a) [CIC §790.03(h)(5)]	2
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	2
CIC §790.03(h)(4)	1
CIC §10172.5(a) [CIC §790.03(h)(5)]	1
SUBTOTAL	**192**

LIFE **2008 Life Written Premium: $612,401,368** **2008 Annuity Written Premium: $69,593,695** **AMOUNT OF RECOVERIES None**	**NUMBER OF CITATIONS**
CIC §10172.5(c) [CIC §790.03(h)(3)]	12
CIC §790.03(h)(3)	10
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	3
CIC §1879.2(a) [CIC §790.03(h)(3)]	1
CCR §2695.5(e)(1) [CIC §790.03(h)(2)]	1
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	1
CCR §2695.7(b) [CIC §790.03(h)(4)]	1
CCR §2695.7(d) [CIC §790.03(h)(3)]	1
SUBTOTAL	**30**

ACCIDENT AND DISABILITY **Long Term Care** **2008 Written Premium: $11,031,851** **AMOUNT OF RECOVERIES $34.02**	**NUMBER OF CITATIONS**
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	18
CIC §790.03(h)(3)	7
CCR §2695.4(a) [CIC §790.03(h)(1)]	6
CCR §2695.7(d) [CIC §790.03(h)(3)]	2
CIC §790.03(h)(1)	1
CIC §790.03(h)(5)	1
CIC §1879.2(a) [CIC §790.03(h)(3)]	1
CIC §10235.9(b) [CIC §790.03(h)(13)]	1
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	1
SUBTOTAL	**38**

TOTAL	**260**

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. NMLIC intends to take the following appropriate corrective action in all jurisdictions: for Individual Disability Income, Group Disability Income and Life lines, NMLIC has revised the fraud warning language on claim forms used in all states, not just California; and, for Individual Disability Income, the pending corrective action regarding the enhancement of Explanation of Benefits will be used in all states, not just in California. For NLTC, the corrective action regarding the revised fraud warning language on claim forms has been extended to all states, not just California.

Money recovered within the scope of this report was $1,146.40 as described in sections number 6(b), 8, 14, and 28 below. Following the findings of the examination, closed claims surveys as described in section 6(b) and 14 below were conducted by the Company resulting in additional payments of $20,660.92. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $21,807.32.

ACCIDENT AND DISABILITY (Disability Income)

1. In 123 instances, the Company failed to provide to the claimant and assignee, if any, an explanation of benefits including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

1(a). In 89 of the 123 instances, the Company failed to identify the source of the "Statutory Payment" shown as an offset on the Statement of Disability Benefits/Explanation of Benefits (EOBS). "Statutory Payment" refers to payments from California State Disability Income (SDI).

Summary of the Company's Response to 1(a): The Company has made changes by updating the first letter to the claimant addressing the SDI offset to explain that the SDI benefits are noted on the EOBS as a "Statutory Payment" and by providing a more detailed explanation to claimants when a partial SDI offset is taken (e.g. a change in the SDI benefit offset amount). These changes were implemented by March 31, 2010.

Additionally, a system upgrade allowing a change to the Company's Explanation of Benefit Statement (EOBS) has been evaluated and by October 31, 2010, the benefit offset noted as "Statutory Payment" on the EOBS will be replaced with "State Disability Insurance".

1(b). In 27 of the 123 instances, the Company failed to provide a clear explanation of the computation of benefits.

Summary of the Company's Response to 1(b): The Company will be adding the following additional information to the Statement of Benefits:

- The Company will state whether each amount being paid represents total or proportionate benefits.
- When proportionate benefits are being paid, where applicable, the Company will indicate the percent of the benefit that the payment represents.
- When there is an increase in the benefits being paid because of an Indexed Income Benefit (IIB) increase, the Company will include a statement indicating that the benefit increased in accordance with the IIB on the policy.
- When benefits are decreased because of the insured/claimant receiving Social Security or State Disability, the Company will include the percent of the benefit that is being paid.
- The Statement of Benefits will include a comment that advises the insured/claimant that the formula for calculating the benefit is set forth in the policy.

The Company must make major systems changes in order to implement these remedial measures. The current target date for implementation is November 12, 2010.

In the interim, the Company will include the following on the Statement of Benefits:

> If you have any questions regarding this statement, please contact (Analyst's Name) at 1-800-748-9493, ext (Analyst's extension). Additional information about the calculation of disability benefits or the amount payable is available upon request. The formula for calculating the benefit is set forth in the policy.

1(c). In four of the 123 instances, the Company failed to provide and/or reference the pre-disability earnings upon which were the bases for the calculation of benefits and failed to include the benefit formula utilized in the policy pertaining to Group Disability Income claims.

Summary of the Company's Response to 1(c): The Company acknowledges that in these instances the information was not provided to the claimants. The Company reminded all benefit analysts on January 13, 2010, to include this information in approval letters.

1(d). In two of the 123 instances, the Company failed to provide a clear computation of the Work Earnings Offset. Although the amount of work earnings was provided to the Company by the Policyholder and/or employer, the offset amount reflected a computed amount. This computation was not disclosed to the claimant in either a letter or the Statement of Disability Benefits.

Summary of the Company's Response to 1(d): The Company acknowledges that the offset amount is reflected in the Statement of Disability Benefits and that the Company's practice is to provide a copy of the policy to the claimant when the claim is approved. The Company has reminded the analyst to provide a more detailed explanation of how the work earnings impact the disability benefit reflecting specific calculation of benefits any time the offset changes.

1(e). In one of the 123 instances, the Company failed to provide a clear computation of the Employer Paid Compensation Offset.

Summary of the Company's Response to 1(e): The Company acknowledges that it should have provided to the claimant an explanation of the offset and how it calculated the offset. When Income From Other Sources is used to reduce disability benefits payable, the Company will provide an explanation in a letter to the claimant of the other income offset(s) and calculation of the disability benefit that is payable. When there is a change in disability benefits payable, the Company will send a letter with an explanation.

2. In 26 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. The Department alleges these acts are in violation of CIC §790.03(h)(3).

2(a). In 24 of the 26 instances, the Company failed to follow its procedure to provide a status letter to the insured/claimant every 30 days while the file was under review.

Summary of the Company's Response to 2(a): The Company acknowledges that it should have provided status letters in 30 day intervals until the final decision was made on the specific claim.

In three instances, the Company discussed the procedures with the individual processors. The Company followed up with these processors by providing them with a performance management plan and by monitoring their work to assure ongoing compliance. Additionally, in mid-2009, the Company began issuing to the supervisor and processor weekly reports that reflect claims pending more than 45 days. Upon receipt of these forms, the supervisor and processor discuss the claims status to assure timely and proper investigation.

With regard to the remaining 21 instances, in team meetings that occurred by April 12, 2010, the Company provided refresher training on the importance of the 30 day status letter to all staff.

2(b). In one of the 26 instances, the Company failed to process correspondence consistently and pursuant to the insured's request.

Summary of the Company's Response to 2(b): The Company acknowledges that it failed to provide the insured with copies of correspondence sent to the insured's representative. The Company manager spoke with the analyst on March 16, 2010, and provided refresher training to ensure the insured is copied when requested.

2(c). In one of the 26 instances, the Company failed to send a letter to the claimant explaining that no benefits were payable because the claimant returned to work during the benefit waiting period.

Summary of the Company's Response to 2(c): The Company agrees that it should have sent a letter to the claimant denying the claim and citing the Beginning Date provision (benefit waiting period). The Company reminded the analyst of this requirement.

3. In 12 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

3(a). In nine of the 12 instances, the Company failed to disclose the applicable benefit waiting period and/or the Total Monthly Benefit Limit that would be available to the insured/claimant or that may apply if the insured/claimant becomes eligible for benefits.

Summary of the Company's Response to 3(a): In five of the nine instances, the Company denied the claims based upon the failure of the employee to provide Proof of

Loss. In these five instances, the Company was in receipt of the Employee Statement, the Employer Statement and/or the Attending Physician's Statement supporting some disability on the part of the claimant. The Company agrees to send a copy of the applicable group disability policy to the claimant when a claim is denied, even when the claimant has failed to provide the required documentation for completing a claim with the Company. Additionally, the claimant will be directed to refer to the policy for answers to questions about their insurance coverage and will be provided with the Company 800 number.

In three of the nine instances, the Company's procedure states that at the time the claim is assigned to an analyst, a Client Summary Statement is provided to the insured. In these three instances, a Client Summary Statement was not sent and therefore, the insured was not provided with the Total Monthly Benefit Limit. The Company provided refresher training to all staff in team meetings by April 9, 2010 emphasizing the importance of sending a Client Summary statement for California claims.

In one of the nine instances, the insured's state of residence was Michigan at the time the Preliminary Notice of Disability was received on an Individual Disability Income claim. The Company's procedure to send the Client Summary Statement is based on the insured's state of residence at the time the notice is received. The Client Summary Statement was not sent in this instance. On August 9, 2010, Individual DI began sending the Client Summary Statement to policyowners who either reside in the State of California when the claim is filed or have a policy that originated in the State of California.

3(b). In two of the 12 instances, the Company failed to disclose the offset of "Other Income" as referenced in the policy.

Summary of the Company's Response to 3(b): The Company agrees that it should have provided to the claimants an explanation of the offset/reduction in benefits including how it calculated the offset/reduction. By April 30, 2010, all claims analysts handling Group Disability Income claims completed California Fair Claims Settlement Practices Regulations refresher training.

Additionally, when Income From Other Sources is used to reduce disability benefits payable, the Company will provide an explanation in a letter to the claimant of the other income offset(s) and calculation of the disability benefit that is payable. When there is a change in disability benefits payable, the Company will send a letter with an explanation.

3(c). In one of the 12 instances, the Company failed to inform the claimant of the policy minimum benefit of $15.00.

Summary of the Company's Response to 3(c): The Company reminded the benefit analyst to include an explanation of the minimum STD benefit in approval letters to the claimant.

4. In six instances, the Company failed to reference the California Department of Insurance in its claim denial. The Department alleges these acts are in violation of

CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges in these instances that it did not include in its claims denials a statement advising the claimant of the potential for a review of the denial by the Department. In conformance with the California Fair Claims Settlement Practices Regulations, it is the Company's policy to include this information for claim denials and rejections (both partial and complete). The Company has taken measures to ensure compliance by distributing to claims personnel on August 28, 2009, a reminder of the required California statement. Additionally, the Company reminded the individuals involved in both the handling and management of the subject claims of this requirement. In an effort to keep claims personnel knowledgeable of regulatory requirements, the Company provides periodic newsletter reminders.

5. In five instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim, or it persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. Specifically, in two instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of the claim. In three instances, the Company persisted in seeking information not reasonably required or material to the resolution of the claim. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

5(a). In one of the five instances, the Company failed to investigate and acknowledge receipt of the Attending Physician's Statement, which was received after the file closure. There was no investigation or activity from March 14, 2007 through August 14, 2007.

Summary of the Company's Response to 5(a): The Company agrees it did not communicate with the claimant after the Company received the Attending Physician's Statement to advise the claimant what information was outstanding. Refresher training was provided to all staff in team meetings by April 9, 2010 emphasizing the importance of communicating every 30 days during the claim review.

5(b). In one of the five instances, the Company failed to consider following up with the claimant for clarification of their alleged inability to work, consider follow up with one of the claimant's doctors for his justification regarding continued work limitations, consider a doctor to doctor consultation, and/or consider an Independent Medical Examination (IME) to clarify the claimant's ability to perform their occupation. Instead, the Company relied on the medical records reviews conducted by Physician Consultants to determine the claimant's restrictions and limitations. The Company subsequently denied the claim on appeal even though the claimant maintained an inability to work and one of their medical providers submitted repeated extensions of disability. The Company did not conduct a thorough, fair and objective investigation prior to making its final decision.

Summary of the Company's Response to 5(b): The Company understands the concerns of the Department and the examiner about discussing a claim with a treating physician and documenting for claims investigation purposes. We acknowledge that this

did not occur in this particular claim. The Company takes seriously the citation and will continue to make efforts to document claim files to evidence that the Company took into account all available and relevant information.

The Company notes that the physicians performing medical reviews of group disability claims were provided training in March 2009 relative to discussions with treating physicians where there are questions about the claimants' disability. The Company provided follow-up training in November 2009. Additionally, in appropriate cases, the Company provides the treating physician with a copy of a medical review and asked the treating physician to submit comments.

The Company also utilizes Independent Medical Exams ("IME") and Functional Capacity Evaluations ("FCE") when Northwestern Mutual has a good faith belief that these tools are reasonably necessary and will result in new information or clarify information already obtained. In situations where the treating physician's opinion and the opinion of the independent medical reviewer differ regarding the Insured's functional abilities, Northwestern Mutual will continue to evaluate and determine in each such case whether a treating physician's review of a medical summary or an IME or FCE may be appropriate to assure that the Company has a complete and correct understanding of the claimants' functional capabilities.

5(c). In three of the five instances, the Company requested information it had already received on three separate occasions in one claim.

Summary of the Company's Response to 5(c): The Company acknowledges the pending claims letters did not correctly address the outstanding information needed to complete the application for disability benefits. In mid-2009, the Company addressed with the Processor the importance of sending letters with the appropriate information reasonably needed to determine liability for the claim. The Company put into place a performance management plan for the Processor and his work was closely monitored to assure consistent quality. Additionally, in mid-2009, the Company developed weekly reports that the Supervisor and Processor receive to provide ongoing oversight.

6. In three instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these acts are in violation of CIC §790.03(h)(5).

6(a). In one of the three instances, the Company denied the Group Disability claim while continuing to pay the Individual Disability claim with the same investigative documentation and similar policy definitions. The Company considered this a common claim in which the Company representatives for the Group claim and the Individual claim coordinated the investigation to avoid duplication.

Summary of the Company's Response to 6(a): The Company acknowledges that given the particular claims facts, a nurse case manager or physician consultant should have more thoroughly analyzed the medications being taken by the claimant. In

January 2010, the Company reminded the analyst to utilize the nurse case managers or the physician consultants when presented with a complex case.

6(b). In two of the three instances, the Company overestimated the amount the claimant would receive from SDI resulting in an underpayment of the Group Short Term Disability (STD) claim. The Company deducted the maximum SDI benefit allowable in the state of California for the specific year. Based on the claimant's pre-disability earnings, the claimant would not have been eligible for the maximum SDI benefit.

Summary of the Company's Response to 6(b): In the first instance, the Company adjusted the SDI Benefits and paid the difference owed. In the second instance, the Company offered to calculate the claim using the SDI tables and reported pre-disability earnings and to pay any additional benefits that may be due plus interest. As a result of the findings of the examination, the Company issued payments of $169.91 including the required interest.

The Company rolled out a new procedure in the fourth quarter of 2009. The Company now estimates the offset based upon 55% of pre-disability earnings as defined under the STD group policy.

In response to the Department's concern that the Company may have underpaid other claims in which the maximum SDI benefit was deducted, the Company conducted an internal survey going back three years from the date the Company began using 55% of the pre-disability earnings as the estimated offset. This resulted in a review of closed claims from December 31, 2006 through December 31, 2009 to determine if the SDI offset benefit resulted in any underpayments.

The Company completed the survey on May 27, 2010, and reported the results to the Department on July 15, 2010. The Company reviewed all 385 paid STD claims during the survey period. The Company paid $16,328.43 in benefits and $3,838.58 in interest on 47 claims in which the CA SDI maximum benefit was deducted.

7. In three instances, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim. Specifically, the Company failed to indicate in letters what additional information has been requested to determine liability for the claim. The Department alleges these acts are in violation of CIC §10111.2(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In one instance in mid-2009, the Company addressed delay in the processing of the claim with the processor. The Company put into place for the processor a performance management plan and closely monitored his work to assure consistent quality. Additionally in mid-2009, the Company developed weekly reports that the supervisor and processor receive to provide ongoing oversight.

In the other instances, the Company agrees that it should have provided additional explanation. In March 2010, the Company completed follow-up training to ensure that the claims analysts conduct regular written communication.

8. In three instances, the Company failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability. The Department alleges these acts are in violation of CIC §10111.2(c) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: A reminder written communication was sent to all claims analysts on March 24, 2010, regarding the need to include interest on any adjusted discrepancy amounts that are issued 30 days following receipt of all information to determine liability. To remedy the errors, the Company calculated the amount of interest that was due at the time of settlement in which interest exceeded $5.00. This resulted in a payment totaling $808.42 for the required interest in one out of the three claims.

9. In three instances, the Company failed to respond to communications within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company acknowledges that in the three instances it did not respond to communications. On March 24, 2010, the Company sent a reminder written communication to all claims analysts regarding the need to ensure timely follow-up communication. By April 9, 2010, the Company had provided to all staff in team meetings refresher training emphasizing the importance of responding to communications within 15 calendar days. In addition, by April 30, 2010, all claims analysts handling Group Disability Income claims completed repeat California Fair Claims Settlement Practices Regulations training.

10. In two general instances, the Company failed to include the California fraud warning on insurance forms. Specifically, the insurance forms for Individual Disability Income and Group Disability Income failed to include the required California fraud warning. The Department alleges these acts are in violation of CIC §1879.2(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company amended the fraud warning language on required forms for Individual Disability Income by April 19, 2010. With regard to Group Disability Income, the Company amended the forms by February 28, 2010.

11. In two instances, the Company failed to pay benefits within 30 calendar days from receipt of information needed to determine liability. The Department alleges these acts are in violation of CIC §10111.2(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges in the first instance that upon receipt of information, it did not pay benefits within 30 days; however, the Company did pay interest in the final payment. The Company discussed the importance of prompt payments with the analyst. In the second instance, the reason for the delay in processing is unclear to the Company. It is the Company's normal and customary practice to make claims decisions within 30 days after receipt of sufficient proof of loss and documentation and if approvable, make payment, if the first payment is due within those 30 days. The Company sent a reminder written communication to all claims analysts on March 24, 2010, regarding the need to adhere to the 30 day payment requirements.

12. In two instances, the Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. Specifically, the Company failed to provide the claimant with reference to the Beginning Date provision of 31 days in the claims denials. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company acknowledges in one instance that additional explanation regarding the Beginning Date was required and in the other instance the processor should have cited the Beginning Date provision in the denial letter when explaining the reason for the file closure. The Company provided follow-up training by means of written communication to all analysts on March 22, 2010, to ensure appropriate phrasing within denial letters to include each reason given that would apply to the denial decision.

13. In one instance, the Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted to the insured. Specifically, the Company approved the claim January 19, 2009, 59 days after proof of loss was received on November 21, 2008. The Department alleges this act is in violation of CIC §790.03(h)(4).

Summary of the Company's Response: The Company agrees it did not communicate with the claimant after receipt of the proof of loss to let the claimant know it received the proofs and to advise when the first benefit was due. Refresher training was provided to all staff in team meetings by April 9, 2010 emphasizing the importance of communicating after receipt of proof of loss to affirm or deny benefits.

14. In one instance, the Company failed to pay interest on a death claim, under a disability policy, that was paid longer than 30 days from the date of death of the insured, pursuant to CIC §10174. Specifically, the Company failed to issue payment with interest on a Survivor Benefit claim paid more than 30 days from the date of death. The Department alleges this act is in violation of CIC §10172.5(a) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company did not include interest for this Survivor Benefit claim. As a result of the findings of the examination, the Company issued a payment totaling $134.05 representing the required interest.

The Company previously has not paid interest on Survivor Benefits claims because the Company did not apply the California interest requirement to Survivor Benefits under a disability plan. The Company will pay interest on a going forward basis as of March 1, 2010. Additionally, the Company provided training on this requirement.

In response to the Department's concern that the Company may have missed other claims in which interest was due, but not paid, the Company conducted an internal survey going back to claims paid on individuals with a date of death of August 1, 2006 or after.

The Company completed the survey on April 30, 2010, and reported the results to the Department on July 15, 2010. The Company reviewed eight Survivor Benefit claims in which payment was made greater than 30 days after the date of death. The Company paid $493.91 in required interest on all eight claims.

LIFE

15. In 12 instances, the Company failed to notify the beneficiary of the specified rate of interest paid on the death benefit. In five of the 12 instances, the policy was issued in California and the beneficiary resided in California. In seven of the 12 instances, the policy was issued in California and the beneficiary resided in a state other than California. The Department alleges these acts are in violation of CIC §10172.5(c) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In November 2008, the Company upgraded and programmed its claims system to include a statement note advising the beneficiary of the rate of interest being paid on the claim. This output was programmed to happen in every claim in which the beneficiary is a resident of California at the time of payment. At that time, the Company did not program its system to advise beneficiaries residing in states other than California of the rate of interest. The Company has since requested system remediation to include the required statements when the policy is issued in California. These system changes were implemented on June 26, 2010.

16. In 10 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. Specifically, in ten instances related to one claim, the Company failed to follow its procedure to provide a status letter to the insured every 30 days while the file was under review. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: It is the Company's practice to provide 30 day status letters in all claim cases; however, in this particular case, the Company faced difficulties in obtaining contact with the spouse based upon Company practice to

obtain approval from the Financial Representative to contact the spouse. In future cases, the Company will not wait for this approval and will abide by the 30 day requirement.

17. In three instances, the Company failed to reference the California Department of Insurance in its claim denial. Specifically, in three instances related to one claim, the Company failed to include reference to the California Department of Insurance in the claims denials. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that it did not include the required language in the denial letters related to the claim. On January 28, 2010, the Company provided additional training and reinforcement to the analyst to help ensure that the regulations are followed for all future claims handled by this individual.

18. In general, the Company failed to include the California fraud warning on insurance forms. The Department alleges this act is in violation of CIC §1879.2(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: On March 23, 2010, the Company amended the fraud warning language on required forms to satisfy the requirements of the regulation.

19. In one instance, the Company failed to acknowledge notice of claim within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(e)(1) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: Although it is the Company's practice to provide an acknowledgement to the claimant within 15 days of notification, the analyst missed the requirement in this case. On January 28, 2010, the Company provided additional training and reinforcement to the analyst to help ensure that the regulations are followed for all future claims handled by this individual.

20. In one instance, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. The Department alleges this act is in violation of CCR §2695.5(e)(2) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The analyst missed the requirement in this case. On January 28, 2010, the Company provided additional training and reinforcement to the analyst to help ensure that the regulations are followed for all future claims handled by this individual.

21. In one instance, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days. The Department alleges this act is in violation of CCR §2695.7(b) and is an unfair practice under CIC §790.03(h)(4).

Summary of the Company's Response: On January 28, 2010, the Company provided additional training and reinforcement to the analyst to help ensure that the regulations are followed for all future claims handled by this individual.

22. In one instance, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim, or it persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. The Department alleges this act is in violation of CCR §2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company mistakenly asked for the claim form on July 18, 2008, even though the Company had previously received it. On January 28, 2010, the Company provided additional training and reinforcement to the analyst to help ensure that the regulations are followed for all future claims handled by this individual.

ANNUITIES

There were no citations alleged or criticisms of insurer practices in this line of business within the scope of this report.

ACCIDENT AND DISABILITY (Long Term Care)

23. In 18 instances, the Company failed to reference the California Department of Insurance in its claim denial. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

23(a). In 15 of the 18 instances, the Company failed to reference the CDI in its denials of non-covered items identified on Explanations of Benefits (EOB).

Summary of the Company's Response to 23(a): As of November 4, 2009, with each EOB on which non-covered items are identified, the Company will include additional correspondence to the insured with the California-required language regarding reviews by the Department of Insurance.

23(b). In three of the 18 instances, the Company failed to reference the California Department of Insurance in denial letters.

Summary of the Company's Response to 23(b): On November 4, 2009, the Company provided refresher training to the claim staff reminding them of this requirement. In addition, the Company will conduct file reviews to ensure compliance.

24. In seven instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. Specifically, the Company failed to follow its procedure to provide a

status letter to the insured every 30 days while the file was under review. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: On November 4, 2009, the Company provided refresher training to the claims staff regarding the necessity of the 30-day status letters. The staff was trained to set automated tasks as reminders to send out the status letters at appropriate intervals. In addition, the Company will conduct file reviews to ensure compliance.

25. In six instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. In three instances, the Company failed to disclose the Maximum Daily Limit that was available to the insured. In the other three instances, the Company failed to disclose the new Maximum Daily Limit pursuant to the Automatic Additional Purchase Benefit before or at the time of the anniversary date of the policy effective date. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company established a procedure in January 2007 to include information about the policy benefits in its initial claim kit letters. On November 4, 2009, the Company trained the staff to set future reminders to include the notification of any increased benefit on each EOB that covers the period that crosses the policy anniversary.

26. In two instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim, or it persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. In one instance, the Company failed to order the medical records or proceed with a Benefit Eligibility Assessment upon receipt of the claim form and authorization. In another instance, the Company did not investigate charges for certain service dates when those services were provided prior to the date determined as the date the insured met the need, excluding them from being counted toward the Beginning Date. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In the first instance, the Company provided refresher training on the California Fair Claims Settlement Practices regulations and the Company's internal service goals to the claims staff. In addition, the Company will conduct file reviews to ensure compliance.

In the second instance, the Company inquired with the care facility and the insured's spouse whether services were provided in June 2007. The Company determined that the insured did not meet the need for care until July 9, 2007. Therefore, even though the insured's spouse provided the Company with additional documentation prior to that determination, the Company was unable to approve the dates for June 2007.

27. In one instance, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. Specifically, the

Company failed to accurately represent the connection between the three-year Benefit Period and the Maximum Lifetime Benefits provision of the policy. The Department alleges this act is in violation of CIC §790.03(h)(1).

Summary of the Company's Response: Going forward, the Company will include information about the amount of the Maximum Lifetime Benefit available under the policy in the initial claims letters.

28. In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Specifically, the Company failed to adjust the number of days counted toward the Beginning Date after receiving proof that an additional day of services counted toward the Beginning Date. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company adjusted the benefits to include reimbursement for one additional day of services and issued a check in the amount of $34.02, including the required interest, on March 5, 2010.

29. In general, the Company failed to include the California specific fraud warning on insurance forms. The Department alleges this act is in violation of CIC §1879.2(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: On February 22, 2010, the Company amended the existing fraud warning language on required forms to satisfy the requirements of the regulation.

30. In one instance, the Company failed to provide the insured whose claim was denied a written notice within 40 days of the date of denial with the reasons for the denial and all information directly related to the denial. Specifically, the Company failed to provide a written explanation of the reason that medical records did not support benefit eligibility. The Department alleges this act is in violation of CIC §10235.9(b) and is an unfair practice under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees that it did not document this information in the January 22, 2009 denial letter to the insured. On November 4, 2009, the Company provided refresher training to the claims staff reminding them of the necessity to communicate all reasons for an adverse determination.

31. In one instance, the Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. Specifically, the Company failed to provide the insured with reference to the applicable exclusion under the contract for the claim denial. The Department alleges this act is in violation of CCR §2695.7(b)(1) and is an unfair practice under CIC §790.03(h)(13).

Summary of the Company's Response: On November 4, 2009, the Company provided refresher training to the claims staff reminding them that they must provide in all

letters in which they communicate an adverse action the provisions of the contract relied upon to make a claim determination. In addition, the Company will conduct file reviews to ensure compliance.